Main text

Introduction

In England and Wales, with the introduction of the 2007 amendments to the Mental Health Act (MHA) 1983, new roles and responsibilities became available to nurses and allied health professionals (Mental Health Act, 2007; National Institute for Mental Health in England, 2008). Where previously the mental health nurse's role under the MHA had primarily been to care for detained patients and to use limited powers of detention under section 5(4), the 2007 Act enabled nurses to become both Approved Clinicians (ACs), Responsible Clinicians (RCs) and Approved Mental Health Professionals (AMHPs). The uptake of those roles by nurses in the years following the 2007 amendments has been limited (Coffey and Hannigan, 2013). In this article we consider why that has been the case and reflect on some of the challenges and opportunities presented by the AC role in particular relation to nurses becoming RCs. The introduction of a revised MHA Code of Practice in April 2015, is an opportune moment to consider what the MHA means to nurses who have taken on this extended role. As a precursor to primary research addressing the experiences and opinions of non medical RCs, we consider the role in the context of international comparisons, the AMHP role and the debate on the ethics of coercion in mental health care as it pertains to mental health nursing practice.

Nurses and the Mental Health Act.

Detention and treatment of people with diagnosed mental disorder in England and Wales is sanctioned and directed by the Mental Health Act (MHA) 1983. The MHA was substantially revised in 2007, at which time nurses, as well as other professionals became eligible to become Approved Mental Health Professionals (AMHPs), a role previously only open to specially trained social workers. Here we will focus on the role of the non-medical AC and RC roles.

The number of people detained under the MHA has increased over recent years. In 2014/15 in England there were a total of 58,399 detentions under The Act, an increase of 5,223 (or 9.8 per cent) compared to 2013/14 (53,176) following a 5.5 per cent rise during 2013/14 and a 3.7 per cent rise during 2012/13 (Health and Social Care Information Centre, 2015). In Wales in 2014-15 1,921 people were admitted in 2014-15 under the

MHA and other legislation, an increase of 229 (14 per cent) from 2013-14 (Statistics for Wales, 2015). Conversely mental health nursing numbers in the UK are declining, leading to calls from the Royal College of Nursing to invest in retention and support for experienced nurses (Royal College of Nursing, 2014). Recruitment of psychiatrists has also proved challenging (Mukherjee, Michael & Wessely, 2013; Imison, Castle-Clarke and Watson, 2016).

Psychiatric nursing emerged as a distinct occupation at the same time as medicine came to dominate treatment approaches for the mentally ill in Great Britain (see Nolan, 2000 for a thorough historical perspective). Laws pertaining to the treatment of the mentally ill developed in Western capitalist countries from the mid 19th century, permitting detention in hospital through sanction by a member of the medical profession, although the balance of power between the medical profession and the state has been negotiated and renegotiated with successive legislation and amendments (Rogers and Pllgrim, 2010).

2015 saw the publication of a revised MHA Code of Practice (Department of Health, 2015), the tone of which reflects the evolution of service user and service provider relationships in recent years. It is a progressive interpretation of the MHA in light of the Mental Capacity Act 2005 and the influence of recovery based approaches to mental health treatment. Within the past decade we have seen nursing roles in mental health extend beyond care coordination and primary nursing, to include nurses as prescribers, nurses as psychological therapists and nurses as consultants. Nurses in the UK may now also be Best Interest Assessors under the Mental Capacity Act. They may take on Specialist Advisory or MHA Reviewer roles with the Care Quality Commission, as well as the new MHA roles described in statute. In all this reflects a Department of Health approach since the mid 1990s that has encouraged mental health nurses and their colleagues to adapt and change in order to better respond to the needs of patients and to offer more workforce flexibility (Care Services Improvement Partnership/ National Institute for Mental Health in England, 2007). This increase in opportunity and responsibility for the professional group who are the largest but also the lowest paid must be seen as a cost saving measure and also typical of the neoliberal ‘new public management’ agenda of the UK governments since Thatcher, whereby deistitutionalisation and devolution of power can on the one hand be sold as increasing user (and nurse) autonomy and agency but also a reduction in expenditure and a focus on risk management and regulation (Carney, 2008). Ramon(2008, p118) has argued

that UK mental health policy is a ‘a hybrid liberal collectivist welfare regime' where members of multidisciplinary teams have been unenthusiastic about neoliberal policies, yet both users and professionals have benefitted from the opportunities presented by devolved and personalised health care.

Prior to the 2007 amendment nurses ‘of the prescribed class’ (that is suitably qualified mental health or learning disability nurses) did have some roles and responsibilities under the MHA. These aspects of mental health practice are still within the nurse’s domain. Nurses have been and still are required to submit reports as evidence to Mental Health Tribunals and related hearings. They are often formally consulted as a ‘statutory consultee’ during reviews of detention and treatment. Ward based nurses may also be involved in the initial detention process for inpatients, through use of the nurses ‘holding power’ for up to six hours under section 5(4). Nurses have most contact with the MHA through the provision of inpatient care for detained patents, with the nursing team administering care and treatment according to the direction of an RC, usually a consultant psychiatrist. Nursing care is thus enshrined in the rubric of ‘medical treatment’ in the MHA. Ward based nurses also commonly undertake devolved duties from hospital managers, such as ensuring the patient’s rights under section 132 have been discussed and that leave from hospital is managed as required under section 17. It may be argued that whilst there has long been provision for nurses to be consulted and involved in various ways, prior to the 2007 amendments, nurses had only a limited scope to take decisions or carry authority under the MHA, save in the administration and enactment of the statutory authority of medical and social work colleagues.

New MHA roles for nurses

There is limited published material on nurses’ new roles and the MHA, and what there is has focused on either reviewing nurses’ knowledge of the legislation or describing the pedagogical challenges of preparing nurses for its use, whether this be use of section 5(4)(Ashmore, 2015; Ashmore and Carver, 2014; Ashmore, 2010) or the exercise of the AMHP powers (Coffey and Hannigan, 2013; Laing, 2012; Bressington, Wells and Graham, 2011). When the new nursing roles have attracted comment both in the UK and in New Zealand, where nurses have been eligible to undertake the RC role since 1999 as well as a role similar to the AMHP, this has been to highlight the longstanding tension for nurses

between care and custody (McKenna et al, 2006; Fishwick, Tait, & O'Brien, 2001). Recently Morriss (2015) has explored the notion of MHA assessment as professional the 'dirty work' of social control, wherein the AMHP takes on those tasks that are necessary but unpalatable to the profession. From her interviews with 17 practicing AMHPs she designates AMHP work as not 'dirty' but complex and draining, although she did find that it conveys high status to the people undertaking the role. Perhaps status comes from owning what is dirty and complex, what may otherwise be designated as ethically murky and conflicted.

Coffey and Hannigan (2013) have recently discussed the nursing profession's adoption of the AMHP role. For them, the challenge nurses face is having to reflect both a medical and social perspective, given nursing's longstanding allegiance with psychiatry. They also explore the difficulties MHA roles may cause in the nurse's pursuit of an ongoing therapeutic relationship. They posit that the limited uptake of training is due to lack of local authority support and opportunities for training and in part due to the philosophical mismatch between the statutory role and nursing identity. To their argument we would add a further observation about the difference between the AMHP and the ASW role.
Historically the fact that the ASW came from a non health background and was not in the employ of an NHS organisation was an important safeguard for the patient facing potential detention in hospital under the MHA. The ASW, under the MHA (MHA 1983) prior to the 2007 amendments, always ensured that not only was there a philosophical distinction between the biomedical and the social 'model' but an organisational one. Put bluntly it is much easier to argue against and adopt a different position to a colleague employed by a different organisation. The AMHP, as protector of human rights, must be undeterred by the traditionally hierarchical organisation of the hospital trust.

The role of the Approved Clinician(AC) and the Responsible Clinician(RC)

An AC is a healthcare professional who is deemed competent to become responsible for the treatment of mentally disordered people who are detained under the MHA. To become an AC a nurse must be a registrant, specialising in mental health or learning disability nursing They must complete specific training and demonstrate competence and continuing professional development within a professional portfolio. Some decisions under the MHA can only be made by an AC. Approval is granted for five year periods by bodies commis-

sioned for this purpose in England and Wales. When an AC is allocated the care of a specific patient, they become the RC for that patient and have specific duties and powers (see Table 1).

ACs who are allocated to appropriate patients as RCs, can undertake the majority of the functions previously performed by Responsible Medical Officers (RMOs) under the previous iteration of the MHA (National Reference Group, June 2010)
. In order to practice as an AC (and thereafter as an RC for specific patients) any nurse must meet demonstrate that they meet a number of criteria and be admitted to a national register. The RC is a position of great significance to the patient and to any professional working clinically with that patient. The RC is the professional in overall charge of their care.

The non-medical RC role does differ significantly from the medical RC role in that only amedical RC can initiate detention and determine capacity to consent to treatment or authorize emergency medical treatment. The non-medical RC can, however, continue a person's detention by renewal of detention, discharge from detention and object to the nearest relatives' opinion. The differences are summarised in Table 1. In New Zealand, by contrast, non medical RCs may take on all aspects of the role, however in most instances they have confined their practice to treatment rather than assessment.(McKenna et al, 2006). It is not clear whether the constraints put on the non medical RC role in England and Wales were as a result of learning from the New Zealand experience, but it does seem that the custom of that country has become policy in England and Wales.

The MHA Code of Practice requires hospital managers to have local protocols in place for the allocation of RCs. Hospital managers must

> 'ensure that the patient's responsible clinician is the available approved clinician with the most appropriate expertise to meet the patient's main assessment and treatment needs.' (Mental Health Act Code of Practice, 2015, para 36.3)

The RC should be the person best placed to direct care, for example where psychological therapies are at the fore, the RC may be a clinical psychologist (or a suitably qualified and experienced nurse). Nurses are involved in a wide range of care and treatment activities and in community mental health settings they commonly act as care coordinators under

the Care Programme Approach so allocation of a nurse as RC is consistent with the MHA Code of Practice guiding principle of 'efficiency and equity' (para. 1.21).

The authority for approving all MHA ACs is devolved to five 'approval panels' across England and Wales. Between them a total of 34 non-medical ACs have been granted approval (personal communication, see Table 2 which outlines the geographical distribution of approvals via these panels). The potential mobility of this workforce and rules about authorization to practice in different jurisdictions mean that numbers of ACs in each areas may vary. Variation according to Health Board was also found in the New Zealand study of non medical RCs (McKenna et al, 2006).

Higher education programmes offering preparation for the AC role for non-medical practitioners have been developed in Newcastle, Cardiff and London. As of March 2016 the overall number of nurses on the register as ACs is fifteen (of whom 4 specialise in Learning Disability). There are sixteen psychologists, no occupational therapists and three social workers. There are considerable challenges to individuals and to organizations in considering this inter-professional division of labour. The information we have is accurate insofar as data is available but there is a need for a comprehensive and definitive survey of the non-medical AC workforce. Where non social worker AMHPs have been surveyed or interviewed the aim has primarily been to consider educational and supervision needs. Where McKenna et al(2006) conducted a survey of non medical RCs in New Zealand their focus was to describe the non medical RC population and the aspects of their role. At this time we do not know the motivations, opportunities and limitations of the role as found by UK non medical RCs, for whom McKenna et al's sample will be a useful comparator. One area to be studied is that of attrition following AC training and preparation, either through lack of access to clinical populations secondary to institutional uncertainty about roles or because of retirement.

The AC role carries a large degree of responsibility and this may deter nurses. To date there is no financial imperative and no guidance on grading for the role although nurses entering the training are likely to already be in senior clinical roles, most likely as nurse consultants. Social workers and medical colleagues may question the necessity and utility of such encroachment onto their traditional territory, inevitably leading to some resistance. Anecdotal evidence does show such resistance, largely in AC trainees being able to find medical supervisors, but this is not universal. Similarly mental health nurse non medical

prescribers have reported that lack of medical supervision has been a barrier to them taking on their role (Ross and Kettles, 2012). Nurses' lack of willingness or opportunity to take up the AC/RC role is also potentially symptomatic of the 'lukewarm' professional engagement with the neoliberal health policy agenda, as described by Ramon (2008),

Published discussion of the ethical and professional aspects of nurses taking on the RC role have been limited. These will be discussed in the rest of this article, drawing on the AC experience of one of the authors (PV).

Implications for practice: coercion and control versus therapeutic engagement

The therapeutic relationship is central to the philosophy of mental health nursing (Hurley, 2009; Norman and Ryrie, 2013) and the balance between care and coercion has perhaps always been a central debate within the profession. Compassion and empathy are tempered by coercion and control (Bray, 1999; Coffey and Jenkins, 2002; Rogers and Pilgrim, 2014; Holyoake, 2014), with inpatient nurses on the one hand enforcing detention under the MHA by preventing patients from leaving hospital, through use of 'locked doors' (van der Merwe et al, 2009) and restrictive practices (Duxbury, 2015) whilst on the other hand seeking to promote a wellbeing and recovery-oriented approach to treatment that centres on hope, optimism and empowerment (Slade, 2010). For as long as mental health nurses are working with patients who are subject to compulsory detention or Community Treatment Orders (CTOs), there will be a fault line in that therapeutic relationship and the recovery-oriented approach, because the patient is not entering into the admission, the relationship or the therapeutic contract voluntarily (Rogers and Pilgrim 2014). The 'coercion context' or 'coercive shadow' is there, even with voluntary patients (Sjostrom, 2006; Szmuckler et al, 2013), and even if final decisions to admit or detain have previously always been in the hand of other professions.

When the mental health nurse was not formally involved in the decision to detain, they may plausibly deny (to the patient and themselves) their complicity in coercion and containment, they may limit their involvement in the 'dirty work' to following orders rather than directing and owning those ethically challenging decisions. Mental health nurses who participate in care and treatment of detained patients must acknowledge their complicity in decisions made under the MHA, even if they have not made the formal decision to detain. It

is possible, therefore, to view the new roles as opportunities for nurses to be more accountable for interpretation of the MHA and to acknowledge and have acknowledged their part in the process. The nurse as RC has the opportunity to inhabit an ethically challenging position, no longer as spectator, informer or enforcer, but as decision maker. Where Hem et al(2016, p13) in their systematic review of the literature on coercion have described mental health nursing as 'a unique moral practice', increased formal involvement in detention whether as AMHP or RC adds a further dimension to that ethical challenge.

Just as the nurse taking on the AMHP role is duty bound to balance a medically dominated narrative of symptoms and diagnosis with challenging medical orthodoxy (previously the province of the ASW), the nurse as AC must absorb and be accountable for decisions that were once the sole province of the psychiatrist. Because the AC/RC has the power to grant and take away leave as well as to direct treatment and community supervision, there is an overt coercive and controlling element to the role . The legal framework of the MHA and the ethical principles that underpin it should safeguard against an abuse of power. The regulatory safeguards within the MHA and its Code of Practice (DH, 2015), for example the provision of Independent Mental Health Advocates; the statutory monitoring undertaken by the Care Quality Commission's Mental Health Act Reviewers; the scrutiny of care and treatment decisions by Second Opinion Appointed Doctors (SOADs) as well as the reviews of detention decisions by hospital managers and tribunals. Recent critiques of mental health law internationally, particularly in light of the UN Convention on the Rights of Persons with Disabilties, have maintained that it is out of step with rights based approaches because potential risk to others and presumed lack of competence are prized above a respect for the autonomy of the individual (Perlin and Szeli, 2008) and is discriminatory against mental illness as a disability (Szmuckler et al, 2013). Certainly where tribunals are concerned there is evidence that they do not offer a sufficient safeguard against abuse of power, particularly where review is at the patient's request rather than automatic or proactive (Carney, 2008). Carney argues that the neoliberal focus on managing risk and addressing needs has been at the expense of respecting human rights.

There is no denying that being responsible for decisions to continue or rescind detention under the MHA gives non-medical RCs additional means of power and control over patients (and involves community supervision under CTO and not only hospital detention). The relationship between nurse and patient is inevitably affected. I (PV) have carried out

nursing roles for three decades. However when I took on the new role of RC, I was anxious that the nature of my relationship with patients would change. I was concerned that patients would see me only as the embodiment of their detention, However the patients I work with in adult rehabilitation settings have made no objection to having a nurse perform this role, perhaps being less concerned with who carries out the role and more with availability of that person and the access to leave of absence, in fact they had more concern over leave of absence than with treatment.

Taylor et al (2009) identify ‘competing duties of care’, between the roles of RC (including a duty to compel participation in treatment) and that of a therapist whose aim is to maintain therapeutic relationship, the foundation of which is trust. As we have discussed, ethical challenge is inherent in mental health nursing practice so nurses should look to theirprofessional code of conduct (‘The Code’) (Nursing & Midwifery Council, 2015) to guide their decision making, the primary purpose of which is to safeguarding the health and wellbeing of the public. According to the Code nurses must ‘*make care and safety your main concern and make sure that dignity is preserved and needs are recognised, assessed and responded to.’* Being the practitioner with overall responsibility for a detained persons care does not compromise how mental health nurses follow the Code but it does change the dynamic of care, a matter which needs to be addressed in clinical supervision and argued in professional and academic fora. Professional supervision (White and Winstanley, 2010) and the provision of evidence that the Code is being followed by nurses as part of revalidation(Nursing and Midwifery Council, 2015), can then become secondary safeguards for the detained patient. That stands true today but does not also state another important consideration: that those who at first implement such roles are in a strong position to shape the future implementation and ensure that there is some nursing within the non-medical responsible clinician role.

Is much of what comes of these new role very dependent on the individual practitioner? Can a nurse be a nurse some of the time and a MHA RC for the rest of their time?

> ‘The personal competence, ethics and initiative of the individual nurse will determine their interpretation of the proposed roles and the success of its implementation.'(Hurley and Linsley, 2007, 540)

There are very few non-medical ACs acting as RCs at present, so learning from and evaluating such roles is important, particularly at a time when mental health and mental capacity law is rapidly changing and acknowledged to be highly complex (Lyons, 2010).
Future amendments to the MHA may address the areas where medical and non-medical RCs are somewhat arbitrarily separated. The need for diagnostic skills is enshrined in the ability to determine the need for a detention to be renewed so therefore why not on the initiation of a detention? The ability to prescribe medicines and determine consent are demonstrable in nursing so why segregate this to a medical body only?

Conclusion

The temptation to dismiss the introduction of non-medical ACs as an exercise in neo liberal workforce modernisation and cost saving is understandable but 'short sighted' (Hanrahan & Hartley (2008), given that the role offers significant opportunities for patients and professionals. Taking on the AC role is an opportunity for nurses to exercise powers and skills within an explicit legal framework. Recognising and engaging with the challenges of the AC/RC role should invigorate the mental health nurses' interpretation of a fundamental dilemma: how to balance care with control, containment with collaboration and least restriction. The RC role, for those senior nurses whose prior involvement in coercive practice has been significant and are well versed in ensuring their interventions are lawful, should be an opportunity for the skillful exposition of their therapeutic skills but also their ethical reasoning.

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